

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

042

1000

1026

-61-031926

STATE FILE NUMBER

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED OCT 16 1961

1. PLACE OF DEATH

a. COUNTY

Buchanan

b. CITY (If outside corporate limits, give TOWNSHIP only)

OR
TOWN St. Joseph,

Length of stay in 1b

50yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Mo

b. COUNTY

Buchanan

c. CITY

OR
TOWN

St. Joseph,

Inside Limits

Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location)

HOSPITAL OR
INSTITUTION

6407 So 12th

Inside Limits

Yes ☒ No ☐

d. STREET

ADDRESS

(If outside, give location)

6407 So 12th

Reside on Farm

Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)

First

Julia

Middle

Fisher

Last

4. DATE
OF
DEATH

Month

Day

Year

Oct. 9, 1961

5. SEX

Female

6. COLOR OR RACE

White

7. Married ☐ Never Married ☐Widowed ☒ Divorced ☐

8. DATE OF BIRTH

Aug. 15, 1890

9. AGE (last birthday)

71

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HR

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (City and state or country)

Ukrainian

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

Martin Malson

13b. MOTHER'S MAIDEN NAME

Petrauda Hartsock

14. NAME OF HUSBAND OR WIFE

none

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

Address

M Nellie Fisher, St. Joseph Mo

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

DUE TO (c)

Bronchial Pneumonia
Cerebral thrombosesINTERVAL BETWEEN
ONSET AND DEATH

36 hrs.

6 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal
disease condition given in PART I (a)PART III. If deceased was female was
there a pregnancy in last 90 days.☐ Yes ☒ No ☐ Unknown19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURYHour
a.m.
p.m.

Month, Day, Year

20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from _____, to 10/9/61 and last saw her him alive on 10.8.61
Death occurred at 12:50 A.M. _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

Burial

10/11/61

Mt. Olivet Cemetery

St. Joseph, Mo

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

St. Joseph, Mo

Oct. 13, 1961

Mrs. Clark Goodell

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

~~or by~~ _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed John E. Rupp

Licensed Embalmer No. 3986

P. O. Address St. Joseph, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.